




Seeking the Right Balance:
Addressing Behaviors that Undermine a Culture of Safety

September 9, 2015

TeamSTEPPS® Behaviors that Undermine Safety Culture

Rules of Engagement

- **Audio for the webinar can be accessed in two ways:**
 1. Through the phone (**Please mute your computer speakers*)
 2. Through your computer
- **A Q&A session will be held at the end of the presentation**
- **Written questions are encouraged throughout the presentation and will be answered during the Q&A session**
 - To submit a question, type it into the Chat Area and send it at any time during the presentation
- **The lines may open for call-in questions during the Q&A session**

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Acknowledgements

- **Project Sponsors**
 - Jim Battles, PhD (AHRQ)
 - Heidi King, MS (DoD)
- **Project Team**
 - **Health Research & Educational Trust (HRET)**

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TeamSTEPPS Master Training

- **Two-day training course**
- **Train-the-trainer approach**
- **Prepares you to serve as a TeamSTEPPS Master Trainer by**
 - Providing instruction on TeamSTEPPS tools and strategies
 - Providing an opportunity to develop and plan your TeamSTEPPS implementation

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Upcoming TeamSTEPPS Events

- **Online Course Availability**
 - Not able to travel? TeamSTEPPS 2.0 Online Master Trainer Course now available. Register at: <https://tslms.org>
- **Learn more and register for all events at www.TeamSTEPPSportal.org**

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Help Line (312) 422-2609

Or email: AHRQTeamSTEPPS@aha.org

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Today's Presenter

- **Gerald B. Hickson, MD**
 - Senior Vice President for Quality, Safety, and Risk Prevention
 - Assistant Vice Chancellor for Health Affairs
 - Joseph C. Ross Chair in Medical Education & Administration
 - Vanderbilt Center for Patient and Professional Advocacy

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Pursuing Reliability

Definition: "Failure free operation over time... effective, efficient, timely, pt-centered, equitable"

Requires:

- Vision/goals/core values
- Leadership/authority (modeled)
- A *safety* culture = willingness to report and address
 - Psychological safety
 - Trust


Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001; Nolan et al. *Improving the Reliability of Health Care*. IHI Innovation Series. Boston: Institute for Healthcare Improvement; 2004; Hickson et al. Chapter 1: Balancing systems and individual accountability in a safety culture. In: Berman S, ed. *From Front Office to Front Line*. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources; 2012:1-36.

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Checklists: The Keys to the Kingdom...



Atul Gawande's 'Checklist' For Surgery Success

JANUARY 05, 2010 12:00 AM ET

Speaking about dealing with unexpected challenges in medicine, Atul Gawande — a surgeon who writes for *The New Yorker* when he's not at his day job at Harvard Medical School — relates a story about a man who came into an emergency room with a stab wound.

SHARE

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But wait...

The NEW ENGLAND JOURNAL of MEDICINE Urbach DR, et al. Introduction of surgical safety checklists in Ontario, Canada. *N Engl J Med.* 2014 Mar 13;370(11):1029-38.

JAMA Surgery Reames BN, et al. A Checklist-Based Intervention to Improve Surgical Outcomes in Michigan: Evaluation of the Keystone Surgery Program. *JAMA Surg.* 2015 Jan 14. doi: 10.1001/jamasurg.2014.2873. [Epub ahead of print].

- **Conclusions:**
 - Adjusted risk of death; surgical complications; SSIs; wound complications, 30-day mortality:

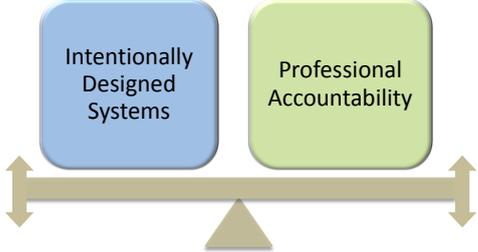
No Difference...

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The Right Balance



Intentionally Designed Systems

Professional Accountability

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Professionalism and Self-Regulation

- Professionals are willing to engage in all aspects of the job – tedious or otherwise – to the best of their ability.
- Professionals commit to:
 - *Technical and cognitive competence*
 - AND**
 - *Clear and effective communication*
 - *Being available*
 - *Modeling respect*
 - *Self-awareness*
- **Professionalism demands self- and group regulation**

Hickson GB, Moore IN, Pichert JW, Benegas Jr M. Balancing systems and individual accountability in a safety culture. In: Berman S, ed. *From Front Office to Front Line*. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources; 2012:1-36.SIU

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Case: “Whistling a Tune”

The following event was reported to you (an authority figure) through your electronic event reporting system.

A nurse observes:
 “During a scheduled procedure we attempted to perform a time-out. Dr. X asked everyone to ‘listen carefully’, and he began whistling the Mickey Mouse Club theme song. He whistles every time...”

Threat to Safety?

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Poll Question

Does this represent a threat to safety?

1. Absolutely
2. Probably
3. Uncertain
4. Probably not
5. Absolutely not

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Poll Question

What % of the time would someone report the event to a responsible party or through an established event reporting system?

1. 0%-20%
2. 20%-40%
3. 40%-60%
4. 60%-80%
5. 80%-100%

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Poll Question

If reported, what % of the time would a medical leader have a conversation with Dr. X?

1. 0%-20%
2. 20%-40%
3. 40%-60%
4. 60%-80%
5. 80%-100%

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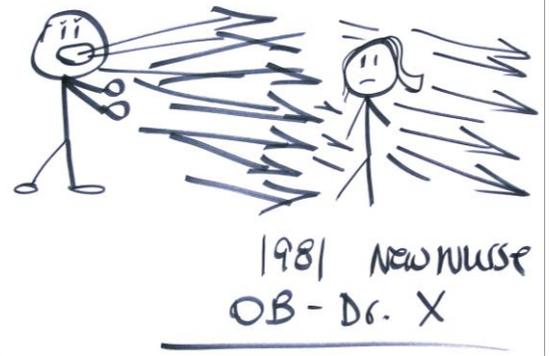
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What are behaviors that undermine a culture of safety?



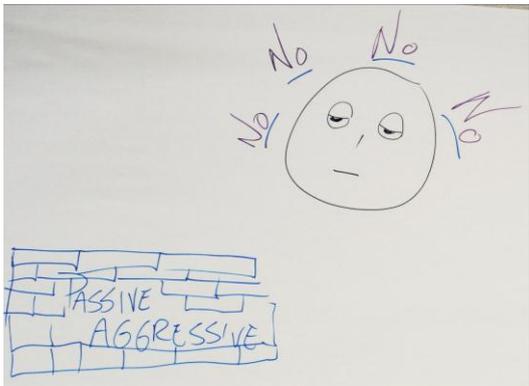
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Definition of Behaviors That Undermine a Culture of Safety

<p>Interfere with ability to achieve intended outcomes</p> <hr/> <p>Threaten safety (aggressive or violent physical actions)</p>	<p>Create intimidating, hostile, offensive (unsafe) work environment</p> <hr/> <p>Violate policies (including conflicts of interest and compliance)</p>
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It's About Safety

Excerpts from Vanderbilt University and Medical Center Policy #HR-027, 2010



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What barriers exist? vs. Why bother acting?



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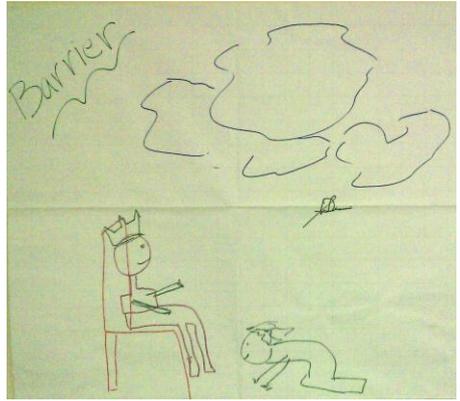
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Consequences of Unsafe Behavior: Patient Perspective

(tip of the iceberg)

- Lawsuits
- Infections/Errors
- Costs
- Drop out
- Bad-mouthing the hospital/ practice to others
- Surgical Complication
- Non adherence/noncompliance

Felso W, et al. How, when, and why bad apples spoil the barrel: negative group members and dysfunctional groups. Research and Organizational Behavior. 2006; 27:175-222.



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Our Challenge

The five most common hospital acquired infections (HAIs) cost the US **\$9.8 billion** annually...

...and we know they are mostly preventable.

Percentage of Total Annual Costs

Infection Type	Percentage	Cost
Catheter-associated urinary tract infections	0.4%	\$0.03 billion
Surgical site infections	33.7%	\$3.3 billion
Ventilator-associated pneumonia	31.6%	\$3.09 billion
Central line-associated bloodstream infections	18.9%	\$1.85 billion
Clostridium difficile infections	15.4%	\$1.51 billion

Data source: Eyal Zimlichman, Daniel Henderson, Orly Tamir, Calvin Franz, Peter Song, Cyrus K. Yamin, Carol Keohane, Charles R. Denham, & David W. Bates. Health Care-Associated Infections: A Meta-analysis of Costs and Financial Impact on the US Health Care System. JAMA Internal Medicine. 2013.

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Failure to Address Behaviors that Undermine a Culture of Safety

Leads To:

- Adoption of unprofessional conduct
- Lessened trust, lessened task performance (*always monitoring disruptive person*)
- Threatened quality and patient safety
- Withdrawal

Felps W et al. How, when, and why bad apples spoil the barrel: negative group members and dysfunctional groups. Research and Organizational Behavior. 2006;27:175-222.

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Respect, trust and team performance

Patient Complaints & Surgical Outcomes

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Patient Complaints

Clear and Effective Communication

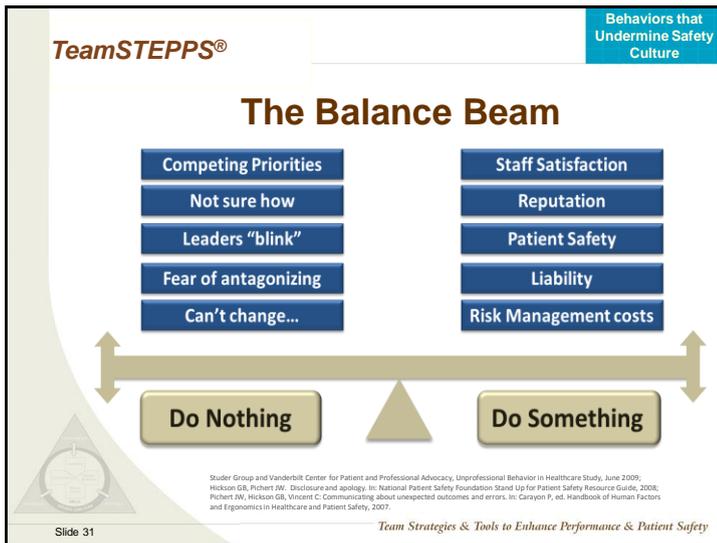
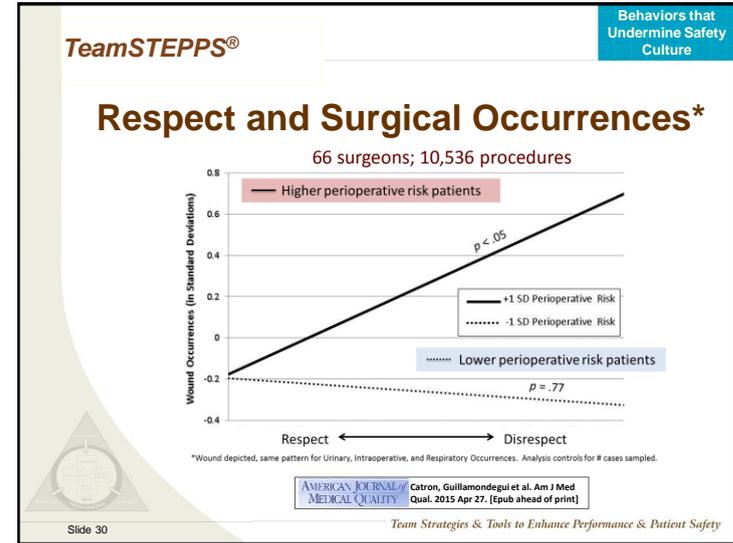
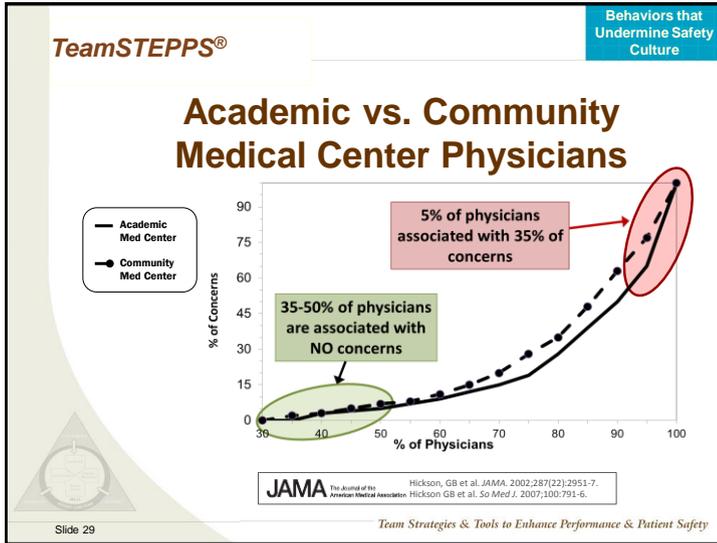
Dr. __ did a very poor job of communicating. He raced through an explanation of what we should expect, then left without giving us a chance to get clarification.

Respectful

Dr. __ didn't listen to me. Dr. __ interrupted me while I was explaining my symptoms and said, "I got it. I already know all I need to know..."

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To “do something” requires more than a commitment to professionalism and personal courage.

It requires a plan (people, process and technology).

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Essential Elements to Promote Reliability

PEOPLE		<ul style="list-style-type: none"> Committed Leadership Project Champions Implementation Teams
PROCESS		<ul style="list-style-type: none"> Clear Goals and Values Policies and Procedures Sufficient Resources Tiered Intervention Model
SYSTEMS		<ul style="list-style-type: none"> Tools, Data and Metrics Reliable Review Process Training

Hickson GB, Pichert JW, Webb LE, Gubbe SE. A complementary approach to promoting professionalism: Identifying, measuring and addressing unprofessional behaviors. Acad Med. 2007 Nov;82(12):2640-2646. Hickson GB, Moore IN, Pichert JW, Benegas Jr M. Chapter 1: Balancing systems and individual accountability in a safety culture. In: Berman S, ed. From Front Office to Front Line. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources;2012:1-36.

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SYSTEMS		<ul style="list-style-type: none"> Tools, Data and Metrics Reliable Review Process Training

Intervention Model (points to Process)

Leadership (points to People)

Training (points to Systems)

Hickson GB, Pichert JW, Webb LE, Gubbe SE. A complementary approach to promoting professionalism: Identifying, measuring and addressing unprofessional behaviors. Acad Med. 2007 Nov;82(12):2640-2646. Hickson GB, Moore IN, Pichert JW, Benegas Jr M. Chapter 1: Balancing systems and individual accountability in a safety culture. In: Berman S, ed. From Front Office to Front Line. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources;2012:1-36.

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What Are “Surveillance Tools”?

Risk Event Reporting System	Patient Relations Department	Staff Concerns	Hand Hygiene Performance	Surgical Bundle Compliance

Hickson GB, Moore IN, Pichert JW, Benegas Jr M. Chapter 1: Balancing systems and individual accountability in a safety culture. In: Berman S, ed. From Front Office to Front Line. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources;2012:1-36.

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Reports of Unprofessional Behavior

RN: Dr. __ entered the room without foaming in...I offered a pair of gloves...he took them and dropped them into the trash can

Anesth: Dr. __ rushed...said to team setting up for surgery, “Let’s get going. Skip all the extra business and get the patient in here...”

RN: Dr. __ asked everyone to ‘listen carefully,’ then began whistling a tune...it was the Mickey Mouse Club theme song.

Hickson GB, Moore IN, Pichert JW, Benegas Jr M. Chapter 1: Balancing systems and individual accountability in a safety culture. In: Berman S, ed. From Front Office to Front Line. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources;2012:1-36.

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Co-Worker Professionalism Reports about VUMC Physicians over a 3 Year Period

Legend:
 - VUMC Attending Physicians and Residents
 - VUMC Attendings with 3 or more Reports (3.1%)
 - VUMC Residents with 3 or more Reports (0.4%)
 - Threshold of Assessment and Review

Annotations:
 - 3% of all Attendings were associated with 46% of behavior/conduct reports.
 - < 1% of all Residents were associated with 10% of behavior/conduct reports.

Percent of Attendings and Percent of Residents July 02, 2012 to July 01, 2015

This material is confidential and privileged information under the provisions set forth in T.C.A. §§ 49-3-150 and 49-13-272 and shall not be disclosed to unauthorized persons.

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Promoting Professionalism Pyramid

References:
 • Ray, Schaffner, Federspiel, 1985.
 • Hickson, Pichert, Webb, Gabbe, 2007.
 • Pichert et al, 2009.
 • Mukherjee et al, 2010.
 • Pichert et al, 2011.
 • Hickson & Pichert, 2012.
 • Hickson et al, 2012.
 • Pichert et al, 2013.
 • Tabbot et al, 2013.

ACADEMIC MEDICINE

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Does any of this really work?

- Improves physicians' prescribing, clinical decision making¹
- Reducing malpractice claims and expenses: By greater than 70%²
- Improving hand hygiene practices: From 50% to greater than 95% compliance³
- Addressing behaviors that undermine a culture of safety⁴

¹Schaffner W, et al. JAMA 1983;250:1728-1732. Ray WA, et al. Am J Public Health 1987;77:1448-1450. Greco PJ, Eisenberg JM. New Engl J Med 1993;329:1271-1273.
²Hickson et al. JAMA. 2002;287(22):2951-57. Hickson et al. South Med J. 2007;100(8):791-6; Pichert et al. In: Henriksen et al, editors. AHRQ, 2008: 421-30; Hickson & Pichert. In: Youngberg, editor. Jones and Bartlett Publishers; 2012: 347-68; Pichert et al. Jt Comm J Qual Patient Saf. 2013;19(5):435-46.
³Tabbot et al. Infect Control Hosp Epidemiol. 2013; 36: 1129-36.
⁴Dmochowski et al. Manuscript in preparation, 2014

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The PARS® Process

Share comparative feedback with tiered interventions using the Pyramid for Promoting Reliability and Professional Accountability.

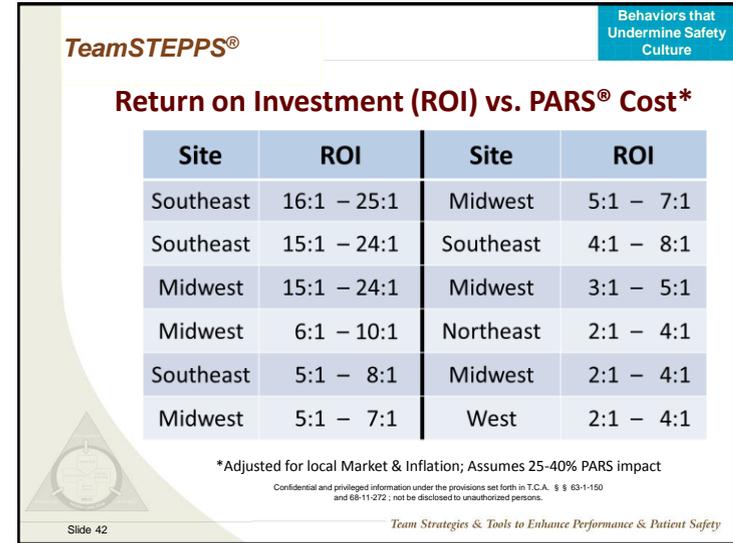
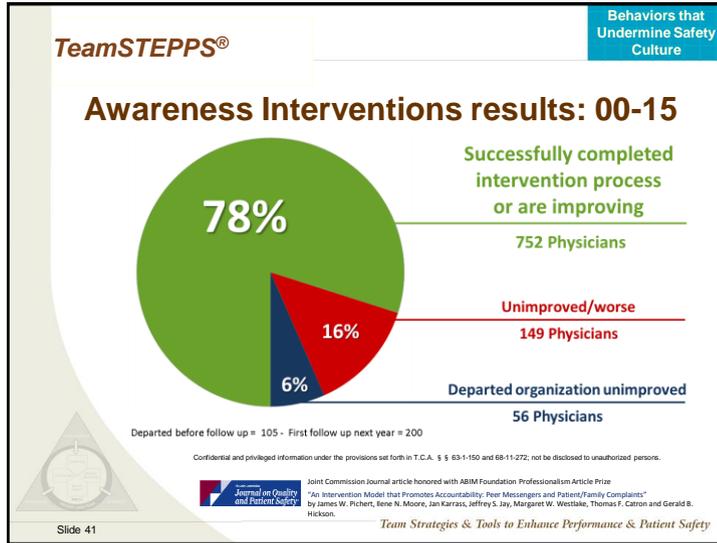
- Identify and train Peer Messengers
- Position for protection from discovery
- Promote accountability

References:
 • Ray, Schaffner, & Federspiel, 1985.
 • Hickson, Pichert, Webb, & Gabbe, 2007.
 • Pichert et al, 2009.
 • Mukherjee et al, 2010.
 • Stimson et al, 2010.
 • Pichert et al, 2011.
 • Hickson et al, 2012.
 • Pichert et al, 2013.
 • Tabbot et al, 2013.

ACADEMIC MEDICINE

Adapted from Hickson, Pichert, Webb, & Gabbe. Acad Med. 2007. ©2013 Vanderbilt Center for Patient and Professional Advocacy

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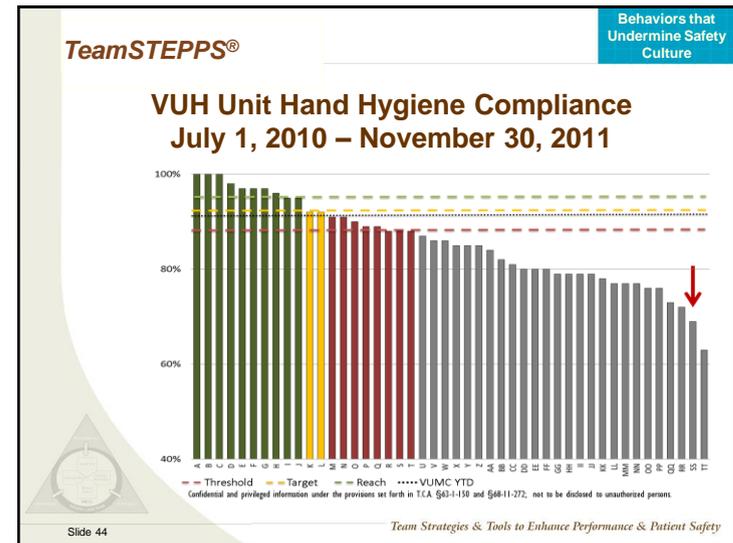


TeamSTEPPS® Behaviors that Undermine Safety Culture

But it is not just about individual performance...

Consider the following challenge...

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TeamSTEPPS® Behaviors that Undermine Safety Culture

Promoting Professionalism Pyramid

Ray, Schaffner, Federspiel, 1985.
Hickson, Pichert, Webb, Gabbe, 2007.
Pichert et al, 2008.
Mukherjee et al, 2010.
Stimson et al, 2010.
Pichert et al, 2011.
Hickson & Pichert, 2012.
Hickson et al, 2012.
Pichert et al, 2013.
Talbot et al, 2013.

ACADEMIC MEDICINE

*includes CMS-defined "condition level" and "immediate jeopardy" safety-related complaints

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VUMC Quarterly HH Compliance June 2009 – December 2014

Start: Jun-09 Jul-Sep-09 Oct-Dec-09 Jan-Mar-10 Apr-Jun-10 Jul-Sep-10 Oct-Dec-10 Jan-Mar-11 Apr-Jun-11 Jul-Sep-11 Oct-Dec-11 Jan-Mar-12 Apr-Jun-12 Jul-Sep-12 Oct-Dec-12 Jan-Mar-13 Apr-Jun-13 Jul-Sep-13 Oct-Dec-13 Jan-Mar-14 Apr-Jun-14 Jul-Sep-14 Oct-Dec-14

Legend: VUMC, FY10 Threshold, FY10 Target, FY11 Threshold, FY11 Target, FY12-14 Threshold, FY12-14 Target, FY12-14 Reach, FY11 Reach

Period of intensified HH program utilizing shared accountability*

Infection Control Hospital Epidemiology Talbot TR, et al. Sustained improvement in hand hygiene adherence: Utilizing shared accountability and financial incentives. Infect Control Hosp Epidemiol. 2013; 34(11, Nov): 1129-1136

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TeamSTEPPS® Behaviors that Undermine Safety Culture

Hand Hygiene Improvement Strongly Correlates with Low Infection Rates

HIGH Infection Rates Correlate with LOW Hand Hygiene Adherence

LOW Infection Rates Correlate with HIGH Hand Hygiene Adherence

As adherence goes up, infection rates go down

Each data point indicates the VUMC-wide monthly HH adherence (x-axis) and infection rates (y-axis) between Jan 2007-Aug 2012.

Monthly Standardized Infection Ratio, All Inpatient Units Combined (CLABSI, CAUTI, VAP combined)

Monthly Hand Hygiene Adherence Rate

Infection Control Hospital Epidemiology Talbot IK, et al. Sustained improvement in hand hygiene adherence: Utilizing shared accountability and financial incentives. Infect Control Hosp Epidemiol. 2013; 34(11, Nov): 1129-1136

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So before you throw away your checklist...

We know what to do, we just have to learn how to collectively...

Intentionally Designed Systems

Professional Accountability

Joint Commission Resources Hickson GB, Moore IN, Pichert JW, Benegas Jr M. Balancing systems and individual accountability in a safety culture. In: Berman S, ed. From Front Office to Front Line. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources; 2012:1-36.SIU

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TeamSTEPPS® Key Principles

Team Structure	Identification of the components of a multi-team system that must work together effectively to ensure patient safety
Communication	Structured process by which information is clearly and accurately exchanged among team members
Leadership	Ability to maximize the activities of team members by ensuring that team actions are understood, changes in information are shared, and team members have the necessary resources
Situation Monitoring	Process of actively scanning and assessing situational elements to gain information or understanding, or to maintain awareness to support team functioning
Mutual Support	Ability to anticipate and support team members' needs through accurate knowledge about their responsibilities and workload

Team Strategies & Tools to Enhance Performance & Patient Safety

Behaviors that Undermine Safety Culture

TeamSTEPPS® Key Principles & Essential Elements

Team Structure		PEOPLE	<ul style="list-style-type: none"> ▶ Committed Leadership ▶ Project Champions ▶ Implementation Teams 	
Communication		PROCESS	<ul style="list-style-type: none"> ▶ Clear Goals and Values ▶ Policies and Procedures ▶ Sufficient Resources ▶ Tiered Intervention Model 	
Leadership			SYSTEMS	<ul style="list-style-type: none"> ■ Tools, Data and Metrics ■ Reliable Review Process ■ Training
Situation Monitoring				
Mutual Support				

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Behaviors that Undermine Safety Culture

Professionalism and Self-Regulation

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Let Us Hear Your Comments and Questions

Now or Later

www.mc.vanderbilt.edu/cppa

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